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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

PLANNED PARENTHOOD OF THE GREAT NORTHWEST AND THE HAWAIIAN ISLANDS, a Washington corporation, Plaintiff, v. STATE OF ALASKA; CAMILLE CARLSON, in her official capacity; BRUCK CLIFT, in his official capacity;	Case No. 3AN-19-11710 CI

CATHERINE HYNDMAN, in her official capacity; SAI-LING LIU, in her official capacity; DOUGLAS MERTZ, in his official capacity; JOY NEYHART, in her official capacity; TIMOTHY OLSON, in his official capacity; SHANNON CONNELLY, in her official capacity; CATHERINE HAMPLE, in her official capacity; EMILY HENRY, in her official capacity; LENA LAFFERTY, in her official capacity; WENDY MONRAD, in her official capacity; DANETTE SCHLOEDER, in her official capacity; and JULIE TISDALE, in her official capacity,

Defendants.

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COMPLAINT

Plaintiff, by and through its undersigned attorneys, brings this complaint against the above-named Defendants and their employees, agents, and successors in office, and in support thereof alleges the following:

I. PRELIMINARY STATEMENT

1. This case challenges an Alaska law and a Board of Nursing policy (collectively "APC Ban") that bar advanced practice clinicians ("APCs") from providing safe, early abortion and miscarriage care, which they are highly qualified to provide. In so doing, the law restricts access to abortion and other gynecological care without medical justification and violates the fundamental rights of Alaskans seeking to end an unwanted pregnancy or suffering a miscarriage.

2. APCs are licensed health care providers with advanced education and training. APCs include advanced practice registered nurses ("APRNs") and physician assistants ("PAs").

3. One of the areas in which APCs commonly receive advanced education and training is women's health, including miscarriage management.[1]

4. Alaska law gives broad authority to APCs to perform many of the same tasks as licensed physicians, including examining, diagnosing, and treating persons, and prescribing and dispensing medical, therapeutic, or corrective measures.[2]

5. The Alaska Board of Nursing defers to the national bodies that certify APRNs to determine the scope of practice[3] of APRNs in Alaska.[4] As such, APRNs in Alaska have "full-practice authority," which is the maximum degree of authority that states provide to APRNs.[5] PAs diagnose and treat medical ailments under the supervision

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[1] Angel M. Foster et al., *Abortion Education in Nurse Practitioner, Physician Assistant and Certified Nurse-Midwifery Programs: A National Survey*, 73 Contraception 408 (2006).
[2] AS 08.64.170 (physician assistants); 08.68.850 (advanced practice registered nurses).
[3] "Scopes of practice" define what types of care health care physicians and APCs can legally provide and under what conditions they can provide that care. State legislatures and licensing boards regulate each profession (APRNs, APCs, etc.) through state practice acts and corresponding regulations. These laws and regulations largely defer to national professional organizations to provide guidance to professionals as to which specific procedures, practices, and competencies are within their scope of practice (based upon their skills, training, experience, etc.), though some states limit the care that APCs may provide beyond that which these national professional organizations would permit.
[4] 12 AAC 44.430.
[5] Am. Ass'n of Nurse Practitioners, *State Practice Environment*, https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment (last updated Dec. 20, 2018).

of physicians. Critically, this supervision does not require that a physician be physically present at every procedure.[6]

6. APCs perform a variety of medical procedures related to reproductive health that reflect their advanced training and licensure, ranging from delivering babies and inserting and removing intrauterine contraceptive devices ("IUDs") to performing endometrial biopsies (the removal of tissue from the uterine lining).[7] They also prescribe medication, including medication to treat early miscarriages, though the APC Ban prevents them from prescribing that same medication to terminate an ongoing pregnancy. The complexity of these health care services (among many others provided by APCs) is similar to or greater than that of early abortion or aspiration care,[8] and childbirth poses far greater risks than abortion.[9] Indeed, APCs in other states can and do provide early

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[6] 12 AAC 40.430; *see also* AS 08.64.170; 12 AAC 40.430; 12 AAC 40.415.
[7] Am. Acad. of Physician Assistants, PAs in Obstetrics and Gynecology (2017), https://www.aapa.org/download/19515; Diana Taylor et al., *Providing Abortion Care: A Professional Toolkit for Nurse-Midwives, Nurse Practitioners, and Physician Assistants* 16–18 (2009), http://apctoolkit.org/wp-content/themes/apctoolkit/PDFs/APCToolkit_COMPLETEBOOK.pdf ("APC Toolkit").
[8] Susan Yanow, *It Is Time to Integrate Abortion Into Primary Care*, 103 Am. J. of Pub. Health 14 (2013); Nat'l Acads. of Scis. Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* 101 (2018) ("Nat'l Acads.") ("The procedure and required skills [for aspiration abortion] are the same as those for the management of spontaneous loss of a pregnancy with uterine aspiration.").
[9] APC Toolkit, *supra* note 7, at 16–18.

abortion care, as well as care for women[10] experiencing miscarriages using the same medications and techniques as those used in early abortion care.[11]

7. Indeed, Alaska not only allows APCs a broad scope of practice but also, recognizing the extreme medical hardships faced by underserved rural communities, *hires* and trains Community Health Aides to "provide emergency, acute, chronic, and preventative health care for all ages."[12] These Aides are not required to have any former higher education; they are trained on the job and *remotely* supervised by physicians *and APCs*. This program has contributed to "dramatically improved" outcomes among the Alaska Native population "including lower infant mortality, longer life expectancy, and dramatically lower rates of tuberculosis."[13]

8. Despite the critical role APCs play in providing health care to Alaskans, and even though early abortion care is extraordinarily safe, Alaska law singles out abortion and makes it a *crime* for APCs—even those supervised by physicians—to

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[10] Plaintiff uses "woman" or "women" as a shorthand for people who are or may become pregnant, but people of all gender identities, including transgender men and gender-diverse individuals, may also become pregnant and seek abortion services, and thus also suffer harm as a result of the APC Ban.

[11] APC Toolkit, *supra* note 7, at 16–18. Upon information and belief, the Alaska Board of Nursing has previously authorized individual APCs to use the safe, straightforward technique of aspiration (which can be used for both miscarriage and early abortion care) for miscarriage management but denied Planned Parenthood's request for general authorization for APCs to provide this care.

[12] Christine Golnick et al., *Innovative Primary Care Delivery in Rural Alaska: A Review of Patient Encounters Seen by Community Health Aides*, 71 Int. J. Circumpolar Health 1 (2012).

[13] *Id.* at 8.

provide this care.[14] Additionally, the Board of Nursing has rejected Planned Parenthood's request to allow its APCs to provide straightforward, low-risk aspiration procedures even to treat miscarriage.[15]

9. These restrictions are both medically unjustified and starkly out of step with the State's treatment of comparable health care services. Peer-reviewed medical literature uniformly demonstrates that APCs can safely and effectively provide early abortion care, and medical authorities ranging from the American College of Obstetricians and Gynecologists, to the American Public Health Association, to the World Health Organization, and the National Academies of Sciences, Engineering, and Medicine ("National Academies") have all concluded that laws prohibiting APCs from providing this care are medically unfounded.[16] Moreover, the U.S. Food and Drug Administration ("FDA"), which regulates pharmaceuticals, allows APCs to provide medication abortion.[17]

10. As with every other health care service, existing scope-of-practice laws in Alaska are more than sufficient to ensure that APCs, like physicians, provide only care

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[14] *See* AS 18.16.010 (the "APC Ban") (criminalizing the provision of abortion by anyone other than a physician).

[15] *See* State of Alaska, Dep't of Commerce, Cmty. & Econ. Dev., Bd. of Nursing, Meeting Minutes, Oct. 23–25, 2013, https://www.commerce.alaska.gov/web/Portals/5/pub/NUR_Meeting_Minutes_2013_10.pdf; Bd. of Nursing, Advisory Opinions: Scope, https://www.commerce.alaska.gov/web/portals/5/pub/NUR_AdOp_Scope.pdf.

[16] *See infra* ¶¶ 59–67.

[17] The FDA's position does not protect providers from state criminal laws such as Alaska's.

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for which they are educationally and clinically prepared and for which competency has been maintained. The APC Ban provides no medical benefit. It serves only to harm Alaska women and the APCs who are legally barred from caring for them.

11. There is limited physician availability throughout Alaska; this shortage has affected health care access around the state.[18] It is expected that this shortage will worsen over the next decade.[19] And the shortage for physicians specializing in women's health is worse than the shortage for *any* other primary care specialty.[20] As a result, many Alaskans now rely upon APCs to meet their health care needs, particularly in the areas of primary and reproductive health care. Banning these highly skilled, highly qualified providers from providing abortion and miscarriage care, therefore, significantly constrains when and where this care is available in Alaska. As a result, many women seeking abortion or miscarriage care face significant and expensive travel burdens and delayed access to care, preventing some from obtaining abortion care altogether.

12. To prevent these medically unjustified restrictions from inflicting further harm, Plaintiff brings this action on behalf of itself and its patients. Alaska's APC Ban violates Plaintiff's patients' right to privacy under the Alaska Constitution. The APC Ban likewise infringes upon Plaintiff's patients' fundamental right to medical and reproductive autonomy, guaranteed by the Constitution of the State of Alaska. Finally,

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[18] Alaska Physician Supply Task Force, Securing an Adequate Number of Physicians for Alaska's Needs 1 (2006), http://dhss.alaska.gov/ahcc/Documents/2006_%20physiciansupply.pdf.
[19] *Id.*
[20] *Id.* at 35.

the APC Ban violates the equal protection rights of Plaintiff and its patients under the Alaska Constitution. Accordingly, the APC Ban is unlawful and unconstitutional as applied to APCs who seek to provide early abortion and miscarriage care, and its enforcement should be permanently enjoined.

II. JURISDICTION AND VENUE

13. This Court has subject matter jurisdiction over Plaintiff's claims under AS 22.10.020.

14. Plaintiff's action for declaratory and injunctive relief is authorized by AS 22.10.020 and Rules 57 and 65 of the Alaska Rules of Civil Procedure.

15. Venue is proper pursuant to Rule 3(c) of the Alaska Rules of Civil Procedure because all Defendants, who are sued in their official capacities, carry out their official duties at offices located in Anchorage.

III. PARTIES

A. Plaintiff

16. Plaintiff Planned Parenthood of the Great Northwest and the Hawaiian Islands ("Planned Parenthood") is a not-for-profit corporation organized under the laws of the State of Washington and doing business in Alaska. It is the largest provider of reproductive health services in Alaska, operating four health centers in the state, in Fairbanks, Anchorage, Juneau, and Soldotna. Planned Parenthood provides a broad range of reproductive and sexual health services to women, men, and teens, including, but not limited to, well person examinations, birth control, testing and treatment for sexually transmitted infections, miscarriage care, cancer screening, and pregnancy testing. Its

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physicians also provide abortion care. Planned Parenthood sues on its own behalf and on behalf of its patients and its APCs. Planned Parenthood employs APCs who would provide early abortion and miscarriage care in Alaska if APCs were legally permitted to provide that service to their patients.

B. Defendants

17. Defendant, the State of Alaska, pursuant to AS 44.80.010, is a proper party to any action challenging a statute or regulation.

18. The individual members of the Alaska State Medical Board ("Medical Board"), Camille Carlson, Bruck Clift, Catherine Hyndman, Sai-Ling Liu, Douglas Mertz, Joy Neyhart, and Timothy Olson, are sued in their official capacity. The Medical Board is a state agency defined in AS 08.64.010. Pursuant to AS 08.64.107, the Medical Board governs the licensing of all PAs in the state. The Medical Board also has the authority to "define ethical, unprofessional, or dishonorable conduct as related to abortions, set standards of professional competency in the performance of abortions, and establish procedures and set standards for . . . care of patients in the performance of an abortion."[21] This includes the authority to investigate and impose disciplinary sanctions for alleged violations of the APC Ban.[22]

19. In addition, the individual members of the Alaska State Board of Nursing ("Board of Nursing"), Shannon Connelly, Catherine Hample, Emily Henry, Lena

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[21] AS 08.64.105.
[22] AS 08.64.326, 18.16.010.

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Lafferty, Wendy Monrad, Danette Schloeder, and Julie Tisdale, are sued in their official capacity. The Board of Nursing is a professional licensing board within the Corporations, Business and Professional Licensing Division of the Alaska State Department of Commerce, Community, and Economic Development.[23] The Board of Nursing governs the licensing of all APRNs in the state.[24] Pursuant to AS 08.68.270 and 08.68.275, the Board of Nursing has the authority to discipline APRNs for failure to comply with the requirements of the APC Ban. The Board of Nursing also has refused to permit Planned Parenthood's APCs to provide aspiration procedures for women suffering miscarriage.[25]

IV. FACTUAL STATEMENT

A. Abortion Is a Critical Component of Women's Health

20. Legal abortion is one of the safest medical services in modern health care.

21. Legal abortion is far safer than carrying a pregnancy to term.[26]

22. The decision to terminate a pregnancy is motivated by a constellation of diverse, complex, and interrelated factors that are intimately related to the individual's core religious beliefs, values, and family circumstances.

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[23] *See* Alaska Dep't of Commerce, Cmty. & Econ. Dev., Div. of Corps., Bus. & Prof'l Licensing, Alaska Bd. of Nurses, https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofNursing.aspx (last visited Aug. 19, 2019).

[24] AS 08.68.100, 08.68.160.

[25] *See* Bd. of Nursing, Advisory Opinions: Scope, *supra* note 15.

[26] Elizabeth G. Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012).

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23. Women seek abortions for a variety of medical, familial, economic, and personal reasons. Fifty-nine percent of women who seek abortions are mothers who have made their decision after weighing the effect of another birth on their ability to adequately care for their existing children.[27] Sixty-six percent plan to have children or have another child when they are older, more financially able to provide for their children, and/or in a more stable, supportive relationship with a partner.[28] Others end a pregnancy in order to be able to leave an abusive partner. Some seek abortions to preserve their life or health by reducing their risk of injury or death; some because they have become pregnant as a result of rape or incest; and others because they decide not to have children at all.

24. About one in four women in this country will have an abortion in her lifetime.[29] The vast majority of these women are poor or have low incomes (75 percent as of 2014).[30]

25. Major medical organizations such as the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family

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[27] Jenna Jerman et al., Guttmacher Inst., Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[28] Stanley Henshaw & Kathryn Kost, *Abortion Patients in 1994–1995: Characteristics and Contraceptive Use*, 28 Fam. Plan. Persp. 140, 144 (1996).

[29] Rachel K Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

[30] Jerman et al., *supra* note 27, at 11.

Physicians, the American Osteopathic Association, and the American Academy of Pediatrics have affirmed that "[r]eproductive healthcare is essential to a woman's overall health, and access to abortion is an important component of reproductive healthcare."[31] Similarly the American Psychiatric Association has deemed access to abortion "a mental health imperative with major social and mental health implications,"[32] and the American Psychological Association has affirmed that "freedom of choice and a woman's control over her critical life decisions promotes psychological health."[33]

26. Women forced to carry unwanted pregnancies to term face a range of serious adverse outcomes. They are exposed to increased risks of death and major complications from childbirth.[34] In fact, the rate of severe maternal morbidity in the United States increased almost 200 percent from 1993 to 2014, affecting more than

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[31] Brief for Amici Curiae ACOG, AMA, AAFP, AOA & AAP in Support of Petitioners, *Whole Woman's Health v. Cole*, No. 15-274, 2016 WL 74948, at *4 (U.S. Jan. 4, 2016); *see also* Am. Acad. of Pediatrics Comm. on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139 Pediatrics 1 (2017) (stating that access to abortion is important for adolescent health and well-being "because of the significant medical, personal, and social consequences of adolescent childbearing"); *see also* Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, Op. No. 613: *Increasing Access to Abortion* 1 (2014, reaffirmed 2019) ("Safe, legal abortion is a necessary component of women's health care.").

[32] Am. Psychiatric Ass'n, *APA Official Actions: Abortions and Women's Reproductive Health Care Rights*, 167 Am. J. Psychiatry 726 (2010), https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2010.167.6.726.

[33] Am. Psychol. Ass'n, *Abortion Resolutions*, http://www.apa.org/about/policy/abortion.aspx (last visited Nov. 13, 2019).

[34] Raymond & Grimes, *supra* note 26, at 216; *see also* Ctrs. for Disease Control & Prevention, *Reproductive Health: Severe Maternal Morbidity*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited Nov. 13, 2019).

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50,000 women.[35] As many as 10 percent of women who carry to term are hospitalized for complications associated with pregnancy aside from hospitalization for delivery.[36] Additionally, delivery itself, whether vaginal or Cesarean, poses significant risks, many times greater than those associated with abortion.[37]

27. Women forced to carry an unwanted pregnancy to term, and their newborns, also are at risk of other negative health consequences such as reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes.[38] Some of these risks may be higher for women living in rural areas, where there are fewer medical providers.[39] The medical risks and adverse outcomes for patients carrying to

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[35] Ctrs. for Disease Control & Prevention, *supra* note 34.
[36] Anne Elixhauser & Lauren M. Wier, Agency for Healthcare Res. & Quality, Complicating Conditions of Pregnancy and Childbirth, 2008 (Statistical Brief #113) (2011), http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf.
[37] *Compare* William M. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Post-Partum Hospitalizations in the United States*, 120 Obstetrics & Gynecology 1029, 1031 (2012), *and* F. Carol Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008), *and* David A. Asch et al., *Evaluating Obstetrical Residency Programs Using Patient Outcomes*, 302 JAMA 1277 (2009), *with* Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 180–81 (2015).
[38] Anshu P. Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18 (2008).
[39] Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, Op. No. 586: *Health Disparities in Rural Women* 1–2 (2014, reaffirmed 2018).

term and their children are worse for patients struggling with poverty, as most of Plaintiff's patients are, as compared to the general population.[40]

28. The risks of carrying a pregnancy to term fall disproportionately upon Alaska Native, African American, and Native American women. Alaska Native, African American, and Native American women die of pregnancy-related causes at a rate about three times higher than do white women.[41]

29. Women forced to carry unwanted pregnancies to term are significantly less likely to be able to bring themselves and their families out of poverty.[42] And women who are victims of intimate partner violence will, in many cases, face increased difficulty escaping that relationship (because of new financial, emotional, practical, and legal ties to that partner).[43]

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[40] Charles P. Larson, *Poverty During Pregnancy: Its Effects on Child Health Outcomes*, 12 Paediatrics & Child Health 673 (2007); Janet L. Peacock et al., *Preterm Delivery: Effects of Socioeconomic Factors, Psychological Stress, Smoking, Alcohol, and Caffeine*, 311 BMJ 531 (1995); Lindsay M. Silva et al., *Low Socioeconomic Status Is a Risk Factor for Preeclampsia: The Generation R Study*, 26 J. Hypertension 1200 (2008).
[41] Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, N.Y. Times, May 7, 2019, https://www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html; Adrian Dominguez et al., Urb. Indian Health Inst., Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas 37 (2016) (finding that maternal mortality was 4.5 times greater for Alaska Native and Native American women than for white women in Urban Indian Health Program service areas).
[42] Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (2015); Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018).
[43] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 144 (2014).

30. It is also important to public health that access to abortion be timely. Although abortion is significantly safer than continuing pregnancy through childbirth, the risks associated with abortion increase as pregnancy advances.[44]

31. Women are often delayed by logistical hurdles in accessing abortion. According to one study, 58 percent of abortion patients in the United States would have preferred to have had their abortion earlier in the pregnancy.[45]

B. Early Abortion Care Is Extremely Safe and Straightforward

32. Early abortions are performed using medications alone or by aspiration, a minor, non-surgical procedure. Both methods are extremely safe and effective.[46]

33. "Medication abortion" is typically performed using a regimen of two oral prescription drugs: mifepristone and misoprostol. Mifepristone, also known as "RU-486" or by its commercial name, "Mifeprex," temporarily blocks the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol, which the patient generally takes at home six to 48 hours after the mifepristone, causes the uterus to contract and expel its

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[44] Nat'l Acads., *supra* note 8, at 77 ("the risk of a serious complication increases with weeks' gestation"); Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735 (2004).
[45] Rachel K. Jones & Jenna Jerman, Guttmacher Inst., Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients 3 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/delays-in-accessing-care.pdf (citing Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334 (2006)).
[46] APC Toolkit, *supra* note 7, at 8–11.

contents. The patient typically passes the pregnancy at home, in a process similar to a miscarriage.[47]

34. Medication abortion is available in the first 10 weeks of pregnancy, measured from the first day of the patient's last menstrual period ("lmp"). After this point, the safest and most common abortion procedure is an aspiration abortion.

35. Aspiration abortions are provided in the first 15 weeks of pregnancy lmp.

36. In an aspiration abortion, the clinician inserts a small sterile tube through the natural opening of the cervix into the uterus. A pump attached to the tube creates suction, which empties the uterine contents. The procedure takes between five and 10 minutes.[48] Although sometimes described as "surgical" to differentiate it from medication abortion, aspiration is non-surgical in the medical sense in that it does not require any incision or a sterile operating field.

37. As the National Academies found, "[c]omplications after medication abortion, such as hemorrhage, hospitalization, persistent pain, infection, or prolonged heavy bleeding, are rare—occurring in no more than a fraction of a percent of patients."[49] The risks are comparably low for aspiration abortion.[50]

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[47] Planned Parenthood, What Can I Expect After I Take the Abortion Pill, https://www.plannedparenthood.org/learn/abortion/the-abortion-pill/what-can-i-expect-after-i-take-the-abortion-pill (last visited Nov. 13, 2019).
[48] APC Toolkit, *supra* note 7, at 10–11.
[49] Nat'l Acads., *supra* note 8, at 55.
[50] *Id.* at 60 (citing Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015)).

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38. Medication and aspiration abortions are the most common abortion procedures Planned Parenthood provides and comprise the overwhelming majority of the abortions Planned Parenthood provides.

C. Aspiration Is Also a Straightforward and Critical Method of Treating Early Miscarriage

39. Miscarriage is an extremely common medical condition; miscarriage before 13 weeks occurs in 10 percent of all clinically recognized pregnancies.[51]

40. Clinicians use both medications and aspiration to remove retained tissue and resolve ongoing bleeding from an incomplete miscarriage.[52]

41. Women who present with hemorrhage, hemodynamic instability, or signs of infection related to miscarriage should be treated urgently with aspiration.[53]

42. Aspiration also may be indicated in other situations involving miscarriage, including the presence of medical comorbidities such as severe anemia, bleeding disorders, or cardiovascular disease.[54]

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[51] Am. Coll. of Obstetricians & Gynecologists, Comm. on Practice Bulletins—Gynecology, ACOG Practice Bulletin No. 200, *Early Pregnancy Loss*, 132 Obstetrics & Gynecology e197 (2018), available at https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb200.pdf?dmc=1&ts=20191002T1930148976.

[52] *Id.* at e200–01.

[53] *Id.* at e201.

[54] *Id.*

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43. Aspiration reduces the risk of miscarriage complications requiring hospitalization.[55]

44. The aspiration procedure used to treat a miscarriage is medically identical, in terms of risks and complexity, to the aspiration procedure for terminating an ongoing pregnancy.

D. Alaska Law Prohibits APCs from Providing Early Abortion Care and the Nursing Board Has Prevented Them from Using Aspiration to Treat Miscarriages.

45. Alaska law states that "[a]n abortion may not be performed in this state unless . . . the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200."[56]

46. Alaska law defines abortion as "the use or prescription of an instrument, medicine, drug, or other substance or device to terminate the pregnancy of a woman known to be pregnant . . . ."[57] This definition encompasses both medication and aspiration abortion.

47. A person in Alaska who is licensed to provide health care, but who is not a physician, and who knowingly performs an abortion, can be subjected to a fine of up to $1,000, imprisonment for up to five years, or both.[58]

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[55] Togas Tulandi & Haya M. Al-Fozan, *Spontaneous Abortion: Management*, Robert Barbieri ed., UpToDate, Waltham, MA: UpToDate Inc., available at https://www.uptodate.com/contents/spontaneous-abortion-management#H2236735649.
[56] AS 18.16.010(a)(1).
[57] AS 18.16.090(1).
[58] AS 18.16.010(c).

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48. Although there is no statutory prohibition on APCs' providing aspiration for miscarriage care, the Board of Nursing has refused to permit Planned Parenthood's APCs to provide this care.[59]

E. Early Abortion and Miscarriage Care Is Well Within the Scope of Practice for Alaska APCs

49. Alaska's APC Ban is wildly out of step with the State's overall approach to regulating APCs' scope of practice.

50. Alaska relies on APCs "more than most states," and "[e]specially in rural areas."[60] "Less restrictive than in many other states, Alaska's state practice and licensure law allows for all nurse practitioners to have full practice rights."[61]

51. As in other states, to obtain an APC license in Alaska, whether as an APRN or as a PA, a clinician must meet rigorous educational, certification, and continuing education requirements.[62]

52. An APRN in Alaska is "a registered nurse licensed to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the board."[63]

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[59] *See* Bd. of Nursing, Advisory Opinions: Scope, *supra* note 15.
[60] Alaska Div. of Pub. Health Sec. of Health Plan. & Sys. Dev., Alaska 2015–2016 Primary Care Needs Assessment at I-13 (May 20, 2016), http://dhss.alaska.gov/dph/HealthPlanning/Documents/Primary%20Care%20Needs%20Assessment/AlaskaPrimaryCareNeedsAssessment_2015-2016.pdf.
[61] *Id.*
[62] *See, e.g.*, AS 08.68.170(c); 12 AAC 40.400, 470, 44.600, 610, 620.
[63] AS 08.68.850.

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53. APRNs include "licensed independent practitioner[s] who [are] licensed to practice as a nurse midwife, a clinical nurse specialist, a nurse practitioner, or a certified registered nurse anesthetist, or in more than one role."[64]

54. In recognition of APRNs' skill and autonomy, as well as their central role in the provision of health care in Alaska, the Board of Nursing proposed regulations in July 2019 to allow APRNs to practice telemedicine.[65]

55. A PA is a "person [who] may perform medical diagnosis and treatment . . . if licensed by the board and only within the scope of practice of the collaborating physician."[66] In Alaska, a PA is authorized to "examine, diagnose, [and] treat persons under the supervision, control, and responsibility of . . . a physician . . . ."[67] Further, a PA "with a valid DEA registration number may order, administer, dispense, and write a prescription for a schedule II, III, IV, or V controlled substance."[68]

56. Although PAs practice under the supervision of a physician, the physician need not be present for procedures.[69] In fact, a PA with at least two years of experience

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[64] 12 AAC 44.380(a).
[65] Advanced practice registered nurse standards of practice for telehealth (proposed July 12, 2019) (to be codified at 12 AAC 44.925), https://www.commerce.alaska.gov/web/Portals/5/pub/NUR-0719.pdf. Like the legislature, the Board of Nursing is attempting to target abortion care for medically unjustified restrictions—in this case, barring APCs from using telemedicine to provide medication *abortion* while otherwise encouraging them to use telemedicine to extend access to care. *See id.* (to be codified at 12 AAC 44.925(4)(B)).
[66] 12 AAC 40.430(a).
[67] AS 08.64.170(a)(1).
[68] 12 AAC 40.450(c).
[69] 12 AAC 40.430.

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can obtain authorization to practice more than 30 miles from the PA's collaborating physician's office.[70]

57. Both APRNs and PAs perform a variety of reproductive health services that are comparably or more complex, and that carry comparable or greater risks, than medication abortion or aspiration.

58. For instance, APRNs and PAs perform endometrial biopsies. During this procedure, they insert a sterile tube through a patient's cervix into the uterus and suction a small piece of tissue from the uterine lining.[71]

59. Similarly, APRNs and PAs perform colposcopies. During this procedure, they use instruments to magnify the cervix and, when appropriate, to remove tissue for biopsy.[72]

60. APRNs and PAs insert (and remove) IUDs through the patient's cervix into her uterus. IUDs are long-acting reversible contraceptive devices. APRNs and PAs also perform intrauterine insemination, a form of assisted reproductive technology in which they inject sperm into a patient's uterus.[73]

61. For each of these procedures, APRNs and PAs often provide lidocaine cervical blocks, a type of local analgesic (painkiller).[74]

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[70] 12 AAC 40.415(d).
[71] APC Toolkit, *supra* note 7, at 18.
[72] *Id.*
[73] *Id.*
[74] *Id.*

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62. There is no medical justification for prohibiting APCs from performing aspiration procedures and prescribing medication for abortion while allowing them to prescribe medication in other comparable contexts and perform services that are more complex and carry greater risk than either medication abortion or aspiration.

F. There Is a Medical Consensus, Based on Extensive Evidence, That Qualified APCs Can Provide Early Abortion Care Just as Safely as Physicians

63. In 2016 the FDA updated the label for medication abortion to clarify that this treatment can be provided by or under the supervision of APCs as well as physicians, based on studies that the FDA recognized "found no differences in efficacy, serious adverse events, ongoing pregnancy or incomplete abortion between the groups."[75]

64. In states across the country, including California, Oregon, Vermont, Illinois, Montana, Washington, Maine, New York, and New Hampshire, APCs are legally permitted to provide medication and aspiration abortion.[76] APCs in New England have been safely and effectively providing abortion care for decades.[77]

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[75] FDA, Ctr. for Drug Evaluation & Res., 020687Orig1s020, Mifeprex Medical Review(s) (Mar. 29, 2016), at 79, https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf.

[76] Donna Barry & Julia Rugg, Ctr. for Am. Progress, *Improving Abortion Access by Expanding Those Who Provide Care* (Mar. 26, 2015), https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/; 225 ILCS 65/65-43; 22 MRSA §1598; NY Pub. Health § 2599-bb. In addition, Colorado, Connecticut, New Mexico, Massachusetts, New Jersey, Hawaii, Rhode Island, and the District of Columbia authorize APCs to provide medication abortion. Kaiser Family Found., Medication Abortion (2018), https://www.kff.org/womens-health-policy/fact-sheet/medication-abortion/.

[77] APC Toolkit, *supra* note 7, at 12.

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65. Based on the provision of this care by APCs in other states, there is a large body of research that evaluates the comparative safety of early abortion care provided by APRNs and PAs and by physicians. The peer-reviewed medical literature has unanimously concluded that APCs can provide medication and aspiration abortions as safely and effectively as physicians.

66. For example, a 2013 study of aspiration abortion services compared 5,812 procedures performed by physicians with 5,675 procedures performed by APRNs and PAs.[78] The study found that "complications were rare" among both groups of practitioners and that such "complications were clinically equivalent between newly trained [nurse practitioners, nurse-midwives, and PAs] and physicians."[79] The results of the study "confirm existing evidence from smaller studies that the provision of abortion by [APCs] is safe and from larger international and national reviews that have found these clinicians to be safe and qualified health care providers."[80]

67. Other studies addressing the safety of advanced practice clinicians' provision of aspiration abortion similarly conclude that such clinicians "provided abortion services comparable in safety and efficacy to those of a physician service."[81]

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[78] *See* Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 457 (2013).
[79] *Id.* at 457, 454.
[80] *Id.* at 459 (footnotes omitted).
[81] Marlene B. Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services*, 94 Am. J. Pub. Health 1352, 1356 (2004) (examining data on abortion care in Vermont); *see also* Shireen J. Jejeebhoy et al., *Can Nurses Perform Manual Vacuum Aspiration (MVA) as Safely and Effectively as Physicians? Evidence from India,*

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68. Based on the unanimous findings from this research, leading medical authorities and professional associations support the provision of medication and aspiration abortions by APCs.

69. The American College of Obstetricians and Gynecologists ("ACOG"), a professional association of more than 58,000 obstetrician-gynecologists, is the nation's leading organization of women's health care providers.

70. ACOG expressly "oppos[es] restrictions [like the Alaska law] that limit abortion provision to physicians only or obstetrician-gynecologists only."[82]

71. In setting forth its opposition to APC bans, ACOG invoked the above-cited studies "show[ing] no difference in outcomes in first-trimester medical and aspiration

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84 Contraception 615, 620 (2011) (finding that aspiration abortion "can be provided with equal safety and effectiveness . . . by nurses as by physicians"); I.K. Warriner et al., *Rates of Complication in First-Trimester Manual Vacuum Aspiration Abortion Done by Doctors and Mid-Level Providers in South Africa and Vietnam: A Randomised Controlled Equivalence Trial*, 368 Lancet 1965, 1970 (2006) ("[F]irst-trimester abortions with manual vacuum aspirations are done equally safely by doctors and trained government-certified MLPs [mid-level practitioners]."); Mary Anne Freedman et al., *Comparison of Complication Rates in First Trimester Abortion Performed by Physician Assistants and Physicians*, 76 Am. J. Pub. Health 550, 553 (1986) (evidence from Vermont demonstrated that "there are no differences in complication rates between those women who had abortions performed by a physician assistant and those who had the procedure performed by a physician").

[82] Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, Op. No. 612: *Abortion Training and Education* (Nov. 2014, reaffirmed 2019), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education.

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abortion by provider type and indicat[ing] that trained APCs can provide abortion services safely."[83]

72. The National Academies of Sciences, Engineering and Medicine ("National Academies") is a body composed of highly esteemed experts that was established by Congress in 1863 to provide independent, objective expert analysis and advice to the nation to inform public policy.

73. The National Academies has similarly concluded that "APCs (physician assistants, certified nurse-midwives, and nurse practitioners) can provide medication and aspiration abortions safely and effectively."[84]

74. The American Public Health Association ("APHA") is the nation's leading public health organization.

75. The APHA recognizes that APC bans like the Alaska law are "[o]utdated" and expressly recommends that APRNs and PAs be permitted to provide abortion and aspiration care.[85]

76. The APHA has further explained that "[e]mpirical evidence . . . demonstrates the competency of [nurse practitioners, nurse-midwives, and PAs] in providing all aspects of medication abortion" and that "research findings indicate the

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[83] *Id.*

[84] Nat'l Acads., *supra* note 8, at 14.

[85] Am. Pub. Health Ass'n, Policy No. 20112, *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

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ability of primary care clinicians—including [nurse practitioners, nurse-midwives, and PAs]—to provide first trimester aspiration abortions with complication rates comparable to those of physician abortion providers."[86]

77. The World Health Organization has likewise recognized that medication and aspiration abortion "can be safely provided" by APCs.[87]

G. The Experience, Training, and Safety Record of APCs at Plaintiff's Clinics Underscore the Ability of APCs to Safely Provide Medication Abortions and Aspiration

78. Planned Parenthood employs or contracts with six APCs across its four locations in Alaska, most of them full-time, and is in the process of hiring an additional full-time APC. All six Planned Parenthood APCs specialize in women's health or family nursing, both of which encompass reproductive health care.

79. The APCs who work at Planned Parenthood are highly qualified clinicians.

80. Like other APCs in Alaska, Planned Parenthood's APCs provide a broad range of health care services, have extremely broad prescriptive authority, and regularly prescribe both FDA-approved and Scheduled medications that are comparable to or higher risk than medication abortion. Indeed, Planned Parenthood's APCs already *do* prescribe one of the medications used in a medication abortion, for purposes of treating miscarriage, and one APC has provided medication abortion itself in a state where this is permitted.

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[86] *Id.*

[87] World Health Org., *Safe Abortion: Technical and Policy Guidance for Health Systems* 65 (2d ed. 2012).

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81. APCs at Planned Parenthood regularly provide all elements of patient care before and after an abortion, including diagnosing and dating the pregnancy (typically by ultrasound), assessing any contraindications (*e.g.*, if the patient has an allergy, or the pregnancy is ectopic—located outside of the uterus), providing options counseling, developing a contraceptive plan, providing follow-up care to ensure that the abortion was complete, and assessing and managing any post-abortion complications.

82. APCs at Planned Parenthood also regularly perform procedures that are comparable in risk and complexity to aspiration, such as IUD insertions and removals, colposcopy and endometrial and vulvar biopsy. One Planned Parenthood APC is currently training to perform vasectomies.

83. To the extent necessary, APCs at Planned Parenthood have the ability to obtain additional training to achieve competency in medication abortion and aspiration.

84. Indeed, Planned Parenthood regularly trains APCs at its Hawaii and Washington clinics in medication abortion care, and Planned Parenthood APCs have been safely providing medication abortions in these states for years.

85. Planned Parenthood also trains APCs to provide aspiration procedures in Washington, and currently has three APCs providing this care there.

86. Moreover, Planned Parenthood regularly trains and credentials APCs in Idaho, Alaska, and Hawaii in procedures that are comparable in skill and complexity to aspiration.

87. Planned Parenthood maintains detailed protocols for training and credentialing APCs in new skills. These typically involve a combination of didactic

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requirements, clinical observation, a period of proctored care, and a review of patient records. This mirrors the training and credentialing process that Planned Parenthood uses for physicians.

H. The APC Ban Significantly Impedes Access to Abortion and Miscarriage Care and Causes Medical, Emotional, and Financial Harm to Alaska Women

88. In 2014, 90 percent of Alaska's boroughs and census areas had no health centers that provided abortions, and 37 percent of Alaska women lived in those areas.[88]

89. In 2011, there were only four health centers in the entire state where a pregnant woman could access an abortion.[89] From some parts of the state, it is not possible to travel by road to any of these four health centers, and patients must travel by boat or by air.

90. Because of Alaska's geographic isolation, Planned Parenthood has had to contract with physicians who already have their own independent practices (which do not include abortion) and who therefore can only be available to Planned Parenthood on an extremely limited basis (in contrast to Planned Parenthood's full-time APCs). Thus, the APC Ban severely limits the abortion services Planned Parenthood can provide. Specifically, it is able to offer aspiration care only approximately one day per month at its clinics in both Fairbanks and Juneau, and only one day per week in Anchorage. Although Planned Parenthood uses telemedicine technology to increase access to medication

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[88] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 Persp. on Sexual & Reprod. Health 7 (2017).
[89] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 Persp. on Sexual & Reprod. Health 9 (2014).

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abortion, even with that technology it only has the physician resources to offer that service approximately one day per week at each of its health centers as well as one day per week at a fourth center in Soldotna.

91. Planned Parenthood's patients often express frustration that appointments are so limited, and many patients are forced to travel vast distances to reduce delay—for example, over 700 miles round-trip from Fairbanks to Anchorage. Other patients, unable to travel that distance, have to wait multiple weeks before they can be seen by a physician (if there is still time at that point)—even though there is no medical reason why they could not receive that care from one of Planned Parenthood's highly skilled APCs.

92. If the APC Ban were removed, all six APCs at Planned Parenthood could immediately begin providing medication abortion and could begin training to provide aspiration care. In addition, Planned Parenthood is hiring one new APC who right away could begin training to provide medication abortions.

93. With this additional staffing, Planned Parenthood could offer medication abortion five days per week in Anchorage, four days per week in Fairbanks, three days per week in Juneau, and one to two days per week in Soldotna. Planned Parenthood could also better accommodate aspiration patients, offering them multiple appointment days each week, including in Soldotna (where currently aspiration procedures are not available). This would significantly decrease delays in obtaining care, allowing more women to end their pregnancy using medications alone, and increasing the likelihood that patients could obtain care from the clinic nearest to them.

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94. Not only does the APC Ban stand as a barrier to Planned Parenthood's provision of abortion and miscarriage care, but it also hinders access elsewhere in the state. Alaska has an acute physician shortage, and APCs are far more likely than physicians to practice in rural and underserved areas of Alaska. According to recent data collected by the Alaska Department of Health and Human Services (the "Department"), several medically underserved regions of the state lack a *single* physician but have one or more practicing APCs: Denali, Yukon-Koyukuk, Skagway-Hoonah-Angoon, Yakutat, Lake and Peninsula, and Wade Hampton.[90] Indeed, the Department has acknowledged that "[e]specially in rural areas, Alaska relies on mid-level providers more than most states," and therefore—with the sole exceptions of abortion and miscarriage care—its "state practice and licensure law" for APCs is by design "[l]ess restrictive than in many other states."[91] Thus, the APC Ban significantly constrains when and where abortion and miscarriage care is available in Alaska. In imposing these constraints, the APC Ban delays patients in obtaining care and forces many patients to travel hundreds of miles farther than they would otherwise have to travel absent the APC Ban.

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[90] Alaska Dep't of Health & Soc. Servs., Health Plan. & Sys. Dev., Alaska Health Care Data Book: Selected Measures, 2007 178 (Nov. 2007), http://dhss.alaska.gov/dph/HealthPlanning/Pages/publications/healthcare/default.aspx.
[91] Alaska 2015-2016 Primary Care Needs Assessment, *supra* note 59, at I-13.

95. Delays increase medical risk, because abortion is safer the earlier in pregnancy it is performed.[92] Risks, though low, increase measurably with each week of gestation.[93]

96. Delays increase cost, because abortion at later gestational ages is a more complex and costly procedure.

97. Delays make it impossible for many women to access medication abortion care, which is only available in the first 10 weeks of pregnancy lmp. Many women strongly prefer medication abortion to a more invasive abortion procedure, and for some women, medication abortion is a safer option.[94]

98. The additional travel burdens and costs imposed by the APC Ban are particularly burdensome for Planned Parenthood's many low-income and rural patients and are likely prohibitive for some of these patients.

99. In 2018, 80,012 people in Alaska were living in poverty.[95] The poverty rate among working-age women, as measured by the federal poverty line, is 10.4 percent—the sixth-highest poverty rate for this group in the country.[96] The rate is also disproportionately high among Alaskans of color: 23.4 percent of Native American

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[92] Nat'l Acads., *supra* note 8, at 77; Bartlett et. al., *supra* note 44, at 735.
[93] *Id.*
[94] *See, e.g.*, Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (2011) (finding 71 percent of study participants said they strongly preferred medication abortion).
[95] TalkPoverty, Alaska 2018, https://talkpoverty.org/state-year-report/alaska-2018-report/ (last visited Nov. 13, 2019).
[96] *Id.*

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women, 14.3 percent of African American women, and 13.3 percent of Latina women live below the poverty line.[97] Moreover, far more women are living below 200 percent of the federal poverty line, which is the measure (often called "low income") considered more accurate by social scientists because it accounts for the cost of child care, medical expenses, utilities, and taxes.[98]

100. Due to a combination of factors, including relative lack of access to medical services and difficulty accessing and affording contraceptives, women with low incomes have more unintended pregnancies, and therefore higher abortion rates, than women with higher incomes.[99] Consequently, the majority of patients seeking an abortion are below or near the federal poverty line.[100] These patients are especially burdened by the APC Ban.

101. Planned Parenthood's patients face other obstacles that, when compounded by the APC Ban, make abortion especially hard to access.

102. Most abortion patients are parents, and must arrange for childcare coverage, which can be harder the farther they have to travel for care.[101]

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[97] Status of Women in the States, *The Status of Women in Alaska, 2015: Highlights*, https://statusofwomendata.org/wp-content/themes/witsfull/factsheets/factsheet-alaska.pdf (last visited Nov. 13, 2019).
[98] Thomas C. Frohlich et al., *Progress in Fighting Poverty in American Has Slowed Despite Recent Economic Recovery*, USA Today, Oct. 1, 2018, https://www.usatoday.com/story/money/economy/2018/10/01/fighting-poverty-america-slowing-despite-recent-economic-recovery/1445296002/.
[99] Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 Contraception 478, 483 (2011).
[100] Jerman et al., *supra* note 27, at 11.
[101] *Id.* at 7.

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103. Many patients work low-wage jobs with limited time off, and no paid time off.

104. Many patients need to keep their decision confidential, to avoid coercion or punishment from family or friends.[102] By delaying patients and forcing them to travel farther, the APC Ban jeopardizes this confidentiality, exposing these patients to a range of harms and potentially depriving them of access to abortion care altogether.

105. Loss of confidentiality is particularly harmful for the 10 percent of abortion patients who suffer intimate partner violence.[103] Many abusive partners coerce their victims into becoming and staying pregnant as a means of control. They often monitor their victims to prevent them from accessing abortion services.[104] Women deprived of access to abortion, and their children, are less likely to escape abusive situations.[105]

106. Women with low incomes often face transportation limitations, such as lacking or sharing a car or having a low-functioning car, that make it particularly hard for

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[102] *See* Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 554*: Reproductive & Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013).
[103] Audrey F. Saftlas et al., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population* 100 Am. J. Pub. Health 1412–15 (2010).
[104] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81(4) Contraception 316 (2010) (finding that domestic violence is highly correlated with unintended pregnancies, due to the reproductive coercion that women face in their abusive relationships, and that one in five women who disclosed domestic violence also reported having experienced pregnancy-promoting behaviors by their abusive partner); Nat'l Domestic Violence Hotline, *1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion* (Feb. 15, 2011), https://www.thehotline.org/2011/02/15/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/.
[105] Roberts et al., *supra* note 43.

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them to travel long distances.[106] Ten percent of Alaska households lack a car.[107] The APC Ban falls particularly hard on women living in these circumstances.

107. The APC Ban also compounds barriers to care for women of color, particularly Native American and black women, who tend to have relatively lower levels of trust in the medical profession,[108] in part because of past racial discrimination in the health care system.[109] The APC Ban does so not only by limiting provider availability but also by preventing patients from receiving care from known, trusted APCs who, as set forth above, are perfectly qualified to provide this care.

108. Thus, the APC Ban severely burdens Planned Parenthood's patients, delaying and impeding them, and imposing on them increased medical risk, costs, and other harms.

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[106] *See* Nat'l Consumer L. Ctr., Working Cars for Working Families: Dangerous and Unreliable Vehicles, (2015) http://www.workingcarsforworkingfamilies.org/promoting-improved-public-policy/dangerous-and-unreliable-vehicles; Elaine Murakami, Fed. Highway Admin. & Jennifer Young, U. of Tenn., Daily Travel by Persons with Low Income 1 (Oct. 1997), http://nhts.ornl.gov/1995/Doc/LowInc.pdf.

[107] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates: Selected Housing Characteristics, Alaska (2018).

[108] L. Ebony Boulware et al., *Race and Trust in the Health Care System,* 118 Pub. Health Rep. 358 (2003); B. Ashleigh Guadagnolo et al., *Medical Mistrust and Less Satisfaction With Health Care Among Native Americans Presenting for Cancer Treatment,* 20 J. Healthcare Poor Underserved 210 (2009) ("In multivariable analyses, race was the only factor found to be significantly predictive of higher mistrust and lower satisfaction scores.")

[109] Boulware et al., *supra* note 108.

109. As a result of these obstacles, the APC Ban also prevents women from accessing care, forcing them to carry to term or attempt self-induction, including by dangerous methods.[110]

110. For women suffering a miscarriage, the APC Ban hinders them from obtaining timely care close to home, thereby placing their health in jeopardy.

V. CLAIMS FOR RELIEF

COUNT I

(Fundamental Right to Privacy — Patients' Right to Privacy)

111. The allegations of paragraphs 1–110 are incorporated as though fully set forth herein.

112. The APC Ban violates Plaintiff's patients' fundamental right to privacy as guaranteed by Article 1, Section 22 of the Alaska Constitution, by obstructing their access to abortion and miscarriage care without adequate justification.

COUNT II

(Fundamental Right to Liberty — Patients' Right to Liberty)

113. The allegations of paragraphs 1–110 are incorporated as though fully set forth herein.

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[110] Alyssa Llamas et al., Jacob's Inst. of Women's Health, George Washington Univ., Public Health Impacts of State-Level Abortion Restrictions: Overview of Research & Policy in the United States 20–27 (2018), https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/Impacts_of_State_Abortion_Restrictions.pdf.

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114. The APC Ban violates Plaintiff's patients' fundamental right to liberty as guaranteed by Article 1, Section 1 of the Alaska Constitution, by obstructing their access to abortion and miscarriage care without adequate justification.

COUNT III

(Equal Protection — Plaintiff and Its Patients)

115. The allegations of paragraphs 1–110 are incorporated as though fully set forth herein.

116. The APC Ban denies to pregnant women who choose to terminate their pregnancies or who suffer miscarriage, and to APCs, the equal protection of the law, as guaranteed by Article 1, Section 1 of the Alaska Constitution.

117. The APC Ban violates the equal protection rights of pregnant women who choose to terminate their pregnancies, as well as those of women suffering miscarriage, by prohibiting them from obtaining care from APCs, where the law authorizes these same providers to perform more complex and higher-risk services for women who choose to carry their pregnancies to term.

118. The APC Ban violates the equal protection rights of APCs, by treating APCs differently than physicians, who are for all relevant purposes similarly situated, without adequate justification.

WHEREFORE, Plaintiff respectfully requests that the Court:

1. Declare that AS 18.16.010 is unconstitutional as applied to APCs who perform medication abortion and aspiration;

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2. Declare that the policy or practice of the Alaska Board of Nursing that precludes APRNs from performing miscarriage management care using aspiration is unconstitutional;

3. Enjoin Defendants and their employees, agents, and successors in office from enforcing AS 18.16.010 against APCs who perform medication and aspiration abortion, and enter this injunction without bond;

4. Enjoin Defendants from disciplining qualified APCs for providing aspiration procedures for miscarriage care;

5. Award Plaintiff costs and attorneys' fees pursuant to AS 09.60.010; and

6. Grant Plaintiff such other, further, and different relief as the Court may deem just and proper.

DATED: December 12, 2019.

STOEL RIVES LLP

By: _____
Bryn R. Pallesen (Bar No. 1810104)

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